THE RECOVERY KERNEL

How to Navigate the Recovery Kernel

For People Recovering from Compulsive Sexual Behavior

Compulsive pornography use, compulsive partner seeking, sex as a way to manage feelings, and compulsive masturbation. A step-by-step route: what to read, in what order, and what to expect. The Kernel's stance throughout: no judgment, no shame as a framework, just the mechanism and what works.

> **HARM REDUCTION RESOURCE — NOT MEDICAL ADVICE. You are not broken, and you are not alone.** This is the behavioral addiction with the most shame attached and the fewest people asking for help, and the Kernel says the shame has to come out of the framework first. If shame is turning into hopelessness or thoughts of harming yourself: **call or text 988.** SAMHSA: 1-800-662-4357.
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> **If a partner or anyone else is in danger,** the National Domestic Violence Hotline is 1-800-799-7233 (the Kernel's resource). **If your sexual thoughts or behavior involve children, or anyone who cannot or does not consent, this guide is not enough: that needs specialist help now, and confidential help exists (see Step 0).**

1. Before you start

This is a route through the Recovery Kernel for people whose sexual behavior has slipped out of voluntary control, and for the partners and clinicians around them. The Kernel begins with biology. Sexual activity is one of the most potent natural dopamine events available, built that way for reproduction, so a system designed to be rewarding can be used compulsively. The problem, it says, is not the drive. It is what happens when the drive bypasses voluntary control. Compulsive sexual behavior disorder is a recognized condition in the WHO's ICD-11 (2022), and the Kernel says it uses the same recovery architecture as every other addiction, with one addition: the sobriety definition has to be specific, because zero sexuality is neither healthy nor the goal. Six rules follow.

- **High drive is not a disorder.** The line is loss of voluntary control and continued harm, not frequency, not which activities, and not whether they are conventional.
- **Shame is the fuel.** It drives the behavior underground and back again. The Kernel says shame as a treatment approach is counterproductive, because the behavior is what relieves the distress the shame creates.
- **Secrecy maintains it.** A hidden pattern cannot be examined, challenged, or held accountable, and discovery trauma is worse than disclosure.
- **Define sobriety specifically.** Write what is out, what leads there, and what healthy expression looks like, ideally with a therapist.
- **Meet what it was doing for you.** For many people, sex was regulating feelings, seeking connection, or chasing novelty. Removing the behavior without meeting that need moves it elsewhere.
- **Do not wait for test results to start.** The genome refines the plan (Main Book, Quick-Start Step 3; Supp. Ch. 5, Step 1b), but honesty and structure come first.

How chapters are cited. "Main Book" is the Recovery Kernel Main Book (Second Edition, Centurian). "Compendium" is the Complete Protocol Compendium. "Supp. Ch. N" is chapter N of the Supplemental Book. The core chapter is Chapter 41 (Compulsive Sexual Behavior). Section numbers (§) refer to sections inside those chapters.

> **A note on sources and numbering.** Supplemental Chapter 41 is complete in the text provided (it ends at its Summary). It cites almost no Compendium protocols by number, so there is little numbering to correct. For the shared behavioral-addiction machinery this guide draws on Compendium Protocol 02 (Behavioral Addictions), which has an entry on sexual compulsion and pornography ("The Counterfeit Eros") and the four disruption points, and on the Kernel's companion pieces the chapter names: Supp. Ch. 40 (No Substance Required), Supp. Ch. 38 (Stop the Bleed), Supp. Ch. 44 (The Transplant), Supp. Ch. 43 (Amends to Self), and the DBT skills in Supp. Ch. 42 (Full Inventory).
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> Here the same pattern shows up as escalating novelty or risk as familiar sources lose their charge — the sobriety-circle definitions in this guide exist to catch that escalation before it happens.
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> Redosing is not the only version of this. Watching peers in a treatment setting negotiate a relapse, getting confident advice from someone untrained in your specific situation, or noticing a prescriber treat a prescribed substance more casually than an illicit one can all trigger the same pattern: a felt doubt read as “the plan must be wrong,” answered by abandoning it. See **The Commandeering Map**, a companion to this series, for the fuller pattern, including how it can differ by genetic profile and what helps when practice-based resistance alone is not enough.

2. The route at a glance

Steps 0 and 1 come first. Steps 2 to 4 can run at the same time. Steps 5 to 9 overlap and are the work of the first year. Step 10 is everything after. "P" means Compendium Protocol; "C" means Centurian Paper.

Step	When	What you do	Turn to
0	Day 0	Triage: safety of you and others, sexual health, substances, and one person to tell.	Supp. Ch. 41 §2, §4.1 Main Book, Quick-Start Step 1 Compendium P01
1	Days 0–14	Name the pattern: CSBD or high drive, which sub-type, and the shame spiral.	Supp. Ch. 41 §2, §2.1, §4 Compendium P02 (Counterfeit Eros)
2	Weeks 1–4	Read the Main Book in order.	Main Book: Who This Book Is For, Quick-Start, Part One (Ch. 1–5) Supp. Ch. 2, 3
3	Weeks 1–4	Order 30× whole-genome sequencing. DRD2, COMT, MTHFR, MAO-A.	Supp. Ch. 5 Step 1 Supp. Ch. 41 §3 Compendium P06
4	Weeks 2–6	Resolve your profile.	Supp. Ch. 5 Steps 2–3, 6 Supp. Ch. 41 §3

Step	When	What you do	Turn to
5	Weeks 1–4	Define sexual sobriety: bottom line, middle circle, healthy outer circle.	Supp. Ch. 41 §7.1
6	Weeks 0–12, then ongoing	Block access, add friction, and surf the urge.	Supp. Ch. 41 §6.2 Compendium P02 (disruption points)
7	From week 1	Take the shame out: tell someone, join a group, get the right clinician.	Supp. Ch. 41 §4, §4.1, §7.3 Supp. Ch. 43
8	Day 1 to Month 6	Biological support, and the medication conversation.	Supp. Ch. 41 §1.1, §7.2 Compendium P07, P17
9	Months 1–12	Trauma, attachment, and affect regulation: build what sex was standing in for.	Supp. Ch. 41 §5, §8.1 Supp. Ch. 39; Ch. 42 (DBT skills)
10	Months 3+, Year 1 to 10	Rebuild natural sexual health and connection. Care for partners. Steward.	Supp. Ch. 41 §8 Supp. Ch. 44, 38, 51 Compendium C-28, P24, P25

3. The route, step by step

Step 0 — Triage (Day 0, before everything)

Four checks, none of them judgment. Your safety: shame can become hopelessness, so keep 988 in reach. Sexual health: risky sexual behavior carries real health risks, and the Kernel lists health risk among the harms that mark the condition, so book a sexual health check and treat it as care, not punishment. Substances: if sex and drugs are tangled together, the chemsex guide in this series (Supp. Ch. 29) is the route for that combination. And one person: the Kernel says the secret cannot be processed in the dark, so decide today who you might tell, a therapist, a trusted friend, or a group, even if you do not tell them yet.

> **Added by this guide (not in the Kernel).** Some sexual behavior is not a habit to manage, it is harm to someone else. If your urges, thoughts, or actions involve children, or people who cannot or do not consent, please contact a confidential specialist service today. In the US, Stop It Now offers a confidential helpline at 1-888-773-8368 for people worried about their own behavior, and similar services exist elsewhere. Getting help early protects others and you. Legal risks are real, so consider speaking with a lawyer if any illegal behavior has occurred. Nothing in this guide is a substitute for that help.

Turn to: Supp. Ch. 41 §2 (what CSBD is and is not) and §4.1 (secrecy as a maintaining factor). Supp. Ch. 29 (chemsex) if drugs are involved. Main Book, Quick-Start Boot Sequence, Step 1. Compendium Protocol 01, Emergency Triage, for an acute crisis state.

Step 1 — Name the pattern (Days 0–14)

The Kernel's ICD-11-based criteria: a persistent pattern of failing to control intense, repetitive sexual impulses despite wanting to; continuing despite significant distress, relationship damage, health risk, or impairment; neglecting health, responsibilities, or important activities because of the time and energy involved; and a duration of about six months or more. High drive under voluntary control and not causing harm is not the disorder, and the Kernel adds that neither frequency, nor which activities, nor how conventional they are, defines it.

The Kernel's four sub-types. Compulsive pornography use: escalating despite wanting to cut down, crowding out sleep and relationships, moving to more extreme content, and sometimes trouble with arousal in real-life situations. Compulsive partner seeking: pursuit, then the interest dissolves, with rising risk as lower-risk encounters lose their charge. Sex as affect regulation: using sex to manage anxiety, depression, loneliness, boredom, or anger, because orgasm's opioid release brings real, brief relief. Compulsive masturbation independent of pornography: driven by the need for the release, and often the form with the most shame. The Compendium adds the general cycle (trigger, craving, behavior, reward, depletion) and its five-question test (compulsive, progressive, harmful and continued, used to escape or regulate emotion, and shame or secrecy): three or more "yes" means the cycle is running.

Then look at the shame spiral, because it is the engine: the behavior occurs, intense shame follows ("what is wrong with me"), the shame produces distress, the behavior is one of the most reliable reliefs for distress, so it recurs, and shame and secrecy deepen. The Kernel says this is not an argument that the behavior is fine, but that treating it with shame is counterproductive.

Turn to: Supp. Ch. 41 §2 (what CSBD is and is not), §2.1 (the sub-types), §4 (the shame spiral). Compendium Protocol 02 (the universal pattern; the mask change: the five-question test; The Counterfeit Eros).

Step 2 — Read the Main Book (Weeks 1–4)

Read it in order once you are settled. If you are overwhelmed, the Quick-Start Boot Sequence is designed to be read on its own. Read "Who This Book Is — and Is Not — For" first: it names situations where the supplement protocols need medical modification, including active psychosis, pregnancy, and severe liver disease.

Read in this order: Who This Book Is For → Quick-Start Boot Sequence → Part One: Ch. 1 (Why Willpower Isn't Enough), Ch. 2 (MTHFR), Ch. 3 (COMT; the Warrior profile is named here), Ch. 4 (CYP450), Ch. 5 (When Systems Collide) → Part Two, the case files (Chapter 6). Ch. 8 (Oxytocin Protocol) is experimental and specialist-only. Ch. 9 (Epigenetic Playground) belongs to Steps 9 and 10. Appendix A and Appendix B are reference.

Then add: Supp. Ch. 2 (Clarity · Restoration · Manning). The Kernel has no compulsive-sexual-behavior case study. Supp. Ch. 40 (No Substance Required), the sister chapter, Supp. Ch. 38 (Stop the Bleed), and Supp. Ch. 43 (Amends to Self). Supp. Ch. 3 (The Addict Virgin Problem) recalibrates timelines. Supp. Ch. 1 (Why They Left You There) is optional reading for the shame, and probably the most relevant one here.

Step 3 — Get your DNA (Weeks 1–4)

The Kernel's recommended route is 30× whole-genome sequencing, which returns a VCF file, a one-time asset you keep. A consumer SNP array is an acceptable start. Homocysteine, B12, and RBC folate are functional markers you can recheck quarterly.

Chapter 41 names four variants. **DRD2 A1** (Reward Deficiency Syndrome, roughly 40 percent fewer D2 receptors by its figure): ordinary rewards register less, so a high-intensity source fills the gap, and it says CSBD is documented at elevated rates in A1 carriers. **COMT Val/Val** (Warrior): fast dopamine clearance, sharp peaks and troughs, and an intensity-seeking, pursuit-driven pull that maps onto partner acquisition and onto the escalation of pornography use. **MTHFR C677T homozygous**: impaired serotonin synthesis, and since serotonin is the satiation signal, a shorter refractory window and faster return of the urge. **MAO-A** (low-activity variants): associated with impulsivity and acting on an impulse without the pause higher serotonin provides. Until results arrive: does ordinary life feel flat compared with this; do you thrive on pursuit and novelty; does the urge return quickly after satisfaction; do you act fast on impulses?

> **Confirm what you are ordering.** Supp. Ch. 5 specifies 30× whole-genome sequencing with VCF output. "WGBS" more commonly names whole-genome bisulfite sequencing, a DNA-methylation assay that is not built to call variants such as MTHFR C677T. Ask the lab for a standard variant file (VCF).

Turn to: Supp. Ch. 5, Step 1. Supp. Ch. 41 §3 (the pharmacogenomics of sexual compulsivity). Compendium Protocol 06, Phenotype Assessment. Main Book Ch. 2 and Ch. 3 self-assessments.

Step 4 — Resolve your profile (Weeks 2–6)

Write your profile down and carry key results on a card. The Kernel's point: the genetics are continuous with those behind substance addiction, not a separate defect.

If your result is…	What changes	Source
DRD2 A1	A baseline reward deficit. Sex was filling a dopamine gap ordinary life leaves. Build several genuine reward sources and consider D2 receptor support with your clinician.	Supp. Ch. 41 §3; Main Book Ch. 3
COMT Val/Val (Warrior)	The pursuit, conquest, and escalating-novelty pattern. Recovery needs a real intensity outlet (adventure, athletic competition, creative or entrepreneurial work) so the drive has somewhere to go.	Supp. Ch. 41 §3, §8.1
MTHFR C677T homozygous	Impaired serotonin synthesis, so a shorter satiation window and faster craving return. 5-MTHF supports the pathway that produces satiation.	Supp. Ch. 41 §3, §7.2; Main Book Ch. 2
MAO-A low-activity	More impulsivity: acting before the pause. Structure and friction matter more, since the pause is what you have less of.	Supp. Ch. 41 §3

Turn to: Supp. Ch. 5, Steps 2, 3, and 6 (gene systems, combined profiles, profile template). Supp. Ch. 41 §3. Main Book Ch. 5 and Appendix A.

Step 5 — Define sexual sobriety (Weeks 1–4)

Unlike substances, sobriety here cannot be "zero." The Kernel's three-circle definition, ideally written with a therapist. The **bottom line behaviors** are the specific actions that count as relapse for you, specific enough to give a clear yes or no, and the Kernel's examples are "no intentional pornography use" for porn use disorder, "no anonymous or casual sexual encounters" for partner seeking, and "no sexual activity as a primary response to emotional distress" for affect regulation. "No sexually compulsive behavior" is too vague to apply. The **middle circle** is behavior that is not relapse but reliably precedes it for you: being alone in a hotel with no one to check in with, certain social media accounts, certain settings without a plan. Knowing it lets you act before the relapse. The **healthy outer circle** names the sexual expression that fits your values and supports healthy sexuality, such as sex in an established relationship, healthy dating, and physical affection that is not compulsive, so that recovery is building toward something. For pornography, the Kernel defines sobriety as no intentional use of visual or written sexual content for arousal, and treats masturbation without pornography as a separate question each person resolves within their own values.

Turn to: Supp. Ch. 41 §7.1 (defining sexual sobriety: bottom line, middle circle, healthy outer circle) and §6.2 (the sobriety definition for pornography).

Step 6 — Block access, add friction, and surf the urge (Weeks 0–12, then ongoing)

The Kernel says the behavior "flourishes in privacy and withers in visibility." Its structural moves: accountability software (Covenant Eyes, Bark, Circle, or similar) that filters content or reports access attempts to a partner who knows you are working on this, installed before the next urge, not during it; device friction (remove the mobile browser if the phone is the main access, or move the computer to a shared room); and removing the private viewing context. For partner seeking, the equivalent is its own example of a rule such as no dating apps after a set hour. It also lists the Compendium's four disruption points: see the trigger (for a week record when, where, what happened in the prior hour, and your body state), surf the wave, block the access (the hierarchy runs from making it impossible, to very difficult, to moderate friction, to willpower alone, which is where the cycle wins), and meet the hunger.

The urge: it peaks and passes in about 15 to 30 minutes if not acted on. Notice it, locate it in your body, breathe, and watch it rise and fall, perhaps with a timer, and treat each successful surf as building tolerance for the next. A cold-water shower or splash on the face, which the Kernel says triggers the diving reflex and a norepinephrine response that interrupts the seeking state, is a quick physiological interrupt. The Kernel cites a roughly 90-day window of abstinence before the reward circuit regains its normal responsiveness, framing it as the start of recovery, not the end. Treat that figure as a rough guide (see the evidence note).

Turn to: Supp. Ch. 41 §6.2 (the pornography recovery protocol). Compendium Protocol 02 (the four disruption points; the hierarchy of protection). Compendium Protocol 01 (the HALT scan).

Step 7 — Take the shame out: tell someone, join a group (From week 1)

The Kernel's case for telling: secrecy keeps the behavior unprocessed, costs the mental energy you need for recovery (a double life is expensive), removes accountability, and leads to discovery trauma in partners that is worse than disclosure would have been. Its resources: certified sex addiction therapists (CSATs, found through iitap.com); Sex Addicts Anonymous (saa-recovery.org), a 12-step program with a broader, more flexible sobriety definition that does not judge specific behaviors; SMART Recovery for people who do not use the 12-step model; and, for partners who experienced betrayal trauma, their own support (COSA, S-Anon, or individual therapy), separate from couples therapy. The Kernel says the partner's trauma is real and needs its own treatment.

> **Added by this guide (not in the Kernel).** How and when to disclose to a partner is a real decision with consequences, and it goes best with a therapist's help, not as a confession in the middle of a bad night. Look for a therapist who is trained in sexual health and compulsive behavior and who is comfortable with your identity, orientation, and values. The evidence base for particular treatment models, including the CSAT model, is limited, so ask any clinician how they work and what they will measure.

Turn to: Supp. Ch. 41 §4.1 (secrecy as a maintaining factor) and §7.3 (professional treatment resources). Supp. Ch. 43 (Amends to Self). Supp. Ch. 51 (Family & Support Network Guide): give it to the people who love you.

Step 8 — Biological support and the medication conversation (Day 1 to Month 6)

The Kernel ties the biology to the tools. Endogenous opioids carry the pleasure signal of orgasm, so it says naltrexone, the same opioid blocker used in alcohol and opioid recovery, has documented effects on compulsive sexual behavior, which is a prescriber's decision. For the supplements, it names NAC as the most important single one for compulsive behavior (restoring glutamate balance in the reward and control circuits), 5-MTHF for the serotonin satiation pathway, zinc (a cofactor in testosterone and oxytocin metabolism), magnesium glycinate (an oxytocin cofactor that calms the anxiety behind sex-as-regulation), and vitamin D (receptors sit throughout the prefrontal control region). The dose tables are in the chapter and belong with your clinician. Run every addition past a pharmacist and an interaction checker (Drugs.com or Medscape).

> **Added by this guide (not in the Kernel).** Some psychiatric medications, including many antidepressants, affect sexual desire and function. If a clinician suggests one, ask directly what it may do to your sexual health and to your recovery plan, and do not stop or change a prescribed medication on your own.

Turn to: Supp. Ch. 41 §1.1 (the full neurochemical profile) and §7.2 (the supplement stack for CSBD). Supp. Ch. 5, Phase One. Main Book Ch. 2, §2.4–2.5. Compendium Protocol 07 (Neuroplasticity), Protocol 17 (The Nightly Restoration).

Step 9 — Trauma, attachment, and what sex was standing in for (Months 1–12)

The Kernel says this is the behavioral addiction with the highest rate of underlying trauma, with an important caveat: it is common enough to be a primary consideration, but not universal. When present, it needs trauma-specific therapy (EMDR, somatic experiencing, trauma-informed CBT) alongside the behavioral work, and when absent it should not be assumed. It names three routes: early sexual trauma that fixes an association between arousal and the trauma response; emotional neglect, so that sex became the person's first and only way to regulate distress; and insecure attachment, where anxious attachment seeks sexual connection to manage anxiety and avoidant attachment has sex without intimacy. The treatment for the second is to build other ways to regulate feelings, not just stop the one you have: exercise, behavioral activation, creative practice, and connection, and the DBT skills in the Full Inventory (the TIPP set) are meant for exactly this. Attachment-focused therapy treats the pattern behind the behavior.

Turn to: Supp. Ch. 41 §5 (the trauma connection) and §8.1 (the transplantation). Supp. Ch. 39 (Complex Trauma and the Substance Connection). Supp. Ch. 42 (Full Inventory: the DBT TIPP skills). Compendium Protocol 01 (the HALT scan).

Step 10 — Rebuild natural sexual health, and steward (Months 3+, Year 1 to Year 10)

The Kernel says recovery is not the absence of sexuality but the recovery of "voluntary, connected, satisfying sexuality," and names four qualities. Voluntary control (you can choose to engage or not, and to stop). Genuine desire as the driver (not relief, urgency, novelty, or habit). Connection (emotional presence, the oxytocin bonding that pornography and serial cycling bypass). Satiation (the normal after-satisfaction state, not an immediate return of craving or shame). The transplant: redirect the intensity and novelty drive into adventure, athletic competition, travel, creative or entrepreneurial work; redirect the intimacy-seeking into cultivating deep, sustained, reciprocal relationships (the Kernel says the thing being sought was always connection, and the vehicle was preventing the destination); and replace the affect-regulation function with better regulators that carry no compulsive cycle. Full Inventory is a structured 180-day plan, and Amends to Self puts the person who lived through it first, which matters for anyone who was harmed. Navigation after the first year shifts from repair to stewardship. Section 4 shows how. Standing tools: Supp. Ch. 44 (The Transplant), Supp. Ch. 38 (Stop the Bleed), Supp. Ch. 6 (Stay Non-Addicted), and Compendium Protocol 02 (with its "Mask Change" caution). Supp. Ch. 5, Step 6 (a weekly AI check-in profile, a reasoning tool and never a provider).

Turn to: Supp. Ch. 41 §8 (the natural sexual health architecture) and §8.1 (the transplantation). Supp. Ch. 44 (The Transplant). Supp. Ch. 43 (Amends to Self). Centurian Paper C-28 (The Recast). Compendium Protocol 24 (Returning to Work), Protocol 25 (The Open Door), Protocol 22 (The Family Field), Protocol 16 (The Isolation Spiral). Supp. Ch. 51 (Family & Support Network Guide).

4. How navigation changes at Years 3, 5, and 10

Shading shows how much attention each track needs. Darkest is primary focus, then active, then maintenance. White cells with gray text are standing safeguards: low effort, never dropped. Numbers in brackets refer to the shifts listed below the table. The Kernel gives almost no timeline beyond the first 90 days, so this whole table is projection.

Track	Months 0–24 (foundation)	Year 3 (consolidate)	Year 5 (build out)	Year 10 (steward)
Safety and health	Health checks; help lines ready	Sexual health checks kept [1]	Annual health check-ups	Safety rules; rehearsed [7]
Biology and genome	DRD2, COMT; MTHFR, MAOA	Retest labs; step stack to upkeep [2]	Prescriber card: DRD2, MAOA	Re-check with new meds and age
Access and privacy	Filters, software; devices in view	Friction kept; privacy limits [3]	Setup reviewed yearly	Friction stays by design
Urges and sobriety circles	Circles defined; surf the wave	Urges rarer; circles updated	Triggers shift: loneliness [4]	Same plan, rehearsed
Shame, secrecy, accountability	Told one person; support group	Shame lifted; accountability held	Accountability steady [5]	Circle kept; honesty routine
Trauma, attachment, coping	Trauma care; coping skills	Coping skills automatic	Attachment work, as needed	Skills kept; support kept
Connection and Manning	Real connection, first seeds	Genuine desire; connection grows	Manning: peer and partners [6]	Mentor or run a group

The seven shifts

1. **Year 3, sexual health checks are kept.** The Kernel lists health risk among the harms of the pattern (Supp. Ch. 41 §2). By year 3, routine checks fit the rhythm of your life and your relationships, and are ordinary care. This shift applies a Kernel concern at a timing chosen for this guide.
2. **Year 3, the stack moves from building to upkeep.** Retest labs (Supp. Ch. 5 Step 1a) and step down toward maintenance. The Trinity chapter says supplements are taken until stable, then tapered and resumed if the system destabilizes; Main Book Ch. 2 treats MTHFR support as maintenance, not cure. Step down to maintenance, not to zero.
3. **Year 3, friction stays and privacy has limits.** The Kernel says the behavior withers in visibility (Supp. Ch. 41 §6.2). By year 3, the software may be off a partner's email or reviewed less often, but the devices-in-the-open and evening rules should stay, since removing them is what usually starts a slide. This shift is extrapolation.

4. **Year 5, triggers shift to loneliness.** The Kernel names emotional distress, loneliness, and boredom as what sex was regulating (Supp. Ch. 41 §2.1). As the original cues fade, loneliness or a loss is the likeliest exposure. Keep the middle-circle awareness and your people. This shift is extrapolation.
5. **Year 5, accountability is steady.** The Kernel says accountability is the most powerful mechanism for change in compulsive behavior (Supp. Ch. 41 §4.1). By year 5 it should be a routine, not a rescue. This shift is extrapolation.
6. **Year 5, Manning.** This is the Trinity's third stage (Supp. Ch. 2). This is extrapolation: peer support and, where you have done your own repair, helping others take the shame out. The Kernel's partner resources suggest that support for partners is part of this work.
7. **Year 10, safety rules stay.** The Kernel says the biology and the drive do not disappear and that shame and secrecy are what re-fuel the pattern (Supp. Ch. 41 §4). Keep the honesty routine, the sexual health checks, and the rules that protect other people.

What is sourced and what is extrapolated. *Shifts 5 and 7 rest directly on Kernel text. Shifts 1 and 2 apply Kernel rules at a timing chosen for this guide. Shifts 3, 4, and 6 are extrapolations. The Kernel gives no compulsive-sexual-behavior timeline beyond the first 90 days.*

5. What outcome to expect

The short version

The Kernel has no case study, timeline, or percentages for this condition, so this section is qualitative and does not make up numbers. If you do the route above, with the shame taken out of the framework, sobriety defined, access blocked, someone told, the biology and trauma addressed, and the drive redirected toward connection, this is what the Kernel supports:

- **The first weeks:** urges peak and pass in about 15 to 30 minutes when not acted on, and structure holds when willpower does not.
- **About 90 days:** the Kernel's rough marker for the reward circuit beginning to regain normal responsiveness, framed as the beginning of recovery.
- **Months 3 to 12:** voluntary control returns, genuine desire replaces relief and urgency as the driver, and satiation and connection begin to come back.
- **By years 3 to 5 the work is maintenance and building. By year 10 you are a steward,** carrying a small set of standing safeguards.

The Kernel does not promise the drive vanishes or that relationships repair on a schedule. It says shame makes it worse, honesty and structure make it better, and that partners need their own support and time.

Milestones, in order

Milestone	When	Expected outcome	Source	Basis
Safe start	Days 0–14	Help lines saved. Sexual health check booked. One person identified to tell. Sex-and-drugs tangle addressed if present.	Supp. Ch. 41 §§2, 4.1	Clinical fact
Sobriety defined	Weeks 1–4	Bottom line, middle circle, and healthy outer circle written down, ideally with a therapist.	Supp. Ch. 41 §7.1	Kernel projection
Access blocked	Weeks 0–4	Accountability software and device friction in place before the next urge. Private viewing context removed.	Supp. Ch. 41 §6.2	Kernel projection
Urge window	Ongoing	An urge peaks and passes in about 15–30 minutes. Each surfed urge builds tolerance for the next.	Supp. Ch. 41 §6.2	Kernel projection
Circuit responsiveness	About 90 days	Reward circuit begins to regain responsiveness to real-world stimuli. The beginning of recovery, not the end.	Supp. Ch. 41 §6.2	Kernel projection
Trauma and attachment work	Months 1–12	Trauma-specific therapy and coping skills replace sex as the main regulator.	Supp. Ch. 41 §5	Kernel projection
Natural sexual health	Months 3–12+	Voluntary control, genuine desire, connection, and satiation return.	Supp. Ch. 41 §8	Kernel projection
Steward phase	Years 3–10	Structure and honesty kept. Sexual health checks. Peer support. Standing safeguards.	Section 4 of this guide	Extrapolated

The Kernel's 12-month numbers: none for this condition

The Kernel has no compulsive-sexual-behavior case study and gives no projection, so there is no 12-month table here, and this guide will not make one up. The nearest relatives are the substance and behavioral guides in this series, especially the behavioral addictions guide, the chemsex guide, and the cocaine and methamphetamine guides for the dopamine and intensity side.

What changes the outcome

- **Shame as a strategy.** The Kernel says it adds to the distress the behavior is medicating.
- **Secrecy and a double life,** which remove accountability and drain the energy recovery needs.
- **A vague sobriety definition.** "No compulsive behavior" cannot be applied. A specific one can.
- **Privacy without friction:** open devices in private, no software, no accountability partner.
- **Ignoring what sex was doing:** regulating distress, seeking connection, or chasing novelty. The need moves to a new vehicle.

- **Untreated trauma or attachment injury,** when they are present.
- **Drugs and sex tangled together.**
- **Neglecting partners' needs.** The Kernel says betrayal trauma is real and needs its own support.
- **A lapse.** The Kernel treats it as information, not judgment (Protocol 21). Tell your accountability person, reset the blocks, and look at the trigger and need underneath it, without spiraling into shame.

How to read the evidence behind the outcomes

The Main Book marks claims with an Evidence Tier: Established, Probable, Emerging, Author/System Experience, and Controversial or Mixed. This guide's reading: the dopamine and endogenous-opioid basis of sexual reward, the Coolidge effect in animals, variable-ratio reinforcement, and the role of shame and secrecy are well supported. Compulsive sexual behavior disorder is in the ICD-11, though as an impulse-control disorder and not as an addiction, and it is not a formal diagnosis in the DSM-5, so the "sex addiction" framing the Kernel uses is contested. Its claims on pornography (reduced prefrontal volume, erectile difficulty in young men with real partners, escalation as tolerance, the 90-day window) are debated in the research and should be treated as hypotheses. The evidence for naltrexone and for NAC in this condition is limited and mixed, the specific roles it gives oxytocin and vasopressin in bonding after repeated sex are speculative, the "40 percent fewer D2 receptors" and "elevated rates in DRD2 A1" figures are the Kernel's own, and the vitamin D and zinc rationales are thin. Its trauma link is real but not universal, and it says so. The natural-architecture comparisons and the years 3 to 10 trajectory sit lower on that scale, so bring them to your clinician as questions, not as facts.

Take these to your clinician or therapist

- An honest description of the behavior: what it is, how often, how long, how it began, what it was doing for you, and what you were feeling or avoiding, in your own words and at your own pace.
- Any trauma, attachment, mood, anxiety, or ADHD history, and any substance use that is tied to sex.
- A request for a sexual health screening, and a question about how any medication you take or may be offered could affect sexual function.
- A question about naltrexone and the other options, and your DRD2, COMT, MTHFR, and MAO-A results if you have them.
- Whether and how to disclose to a partner, with the therapist's help, and where your partner can find their own support.